TO: Mary Helmers, ND Medical Assistance
FROM: Greg Lord, MAMES State Chair
DATE: October 23, 2008
SUBJECT: ND MAMES Providers Questions for ND Medical Assistance

11/5/08: Barb Stockert cancelled this meeting due to forecast of severe weather. She has asked that the responses be sent to her and she will disperse the information to all DME Task Force members to review and respond. At this time the meeting will not be rescheduled unless providers feel necessary.

11/21/08: Updated with Claims Policy Responses

These questions are compiled & edited by Greg Lord of Great Plains Rehabilitation Services, 701-530-4000. Members from the ND MAMES task force will meet NDMA at the North Dakota State Capital in Bismarck at 1:00 to 2:30 pm, Thursday, November 6, 2008

Medical Services General Statement: The main purpose of the DME task is to be a working group to discuss current policy and to bring recommendations to the table for Medical Services to take into consideration. It is not meant to discuss individually denied cases. The Department decisions are based on 42 CFR 440.230(d) and the North Dakota Administrative Code 75-02-02-08, which allows the Department to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures.

The purpose of utilization review is to reduce unnecessary medical services. An individual or organization, on behalf of an insurer, reviews the necessity, use, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

Recipients and providers are informed of their right to fair hearing when denials are issued. Many of the questions in this document are related to individual denials and therefore will not be addressed at anytime during this meeting (questions 2, 3, 4, 8, 19, 20).

1. CPAP

If a ND Medical Assistance recipient is Medicare-primary and ND Medicaid-secondary, is it really necessary to ask ND MAMES Providers to supply NDMA documentation that the recipient is compliant with their CPAP at three months? The recipient has already established compliancy for Medicare at two months.

Going forward is NDMA going to follow the newly established Medicare CPAP guidelines (November 1, 2008)?

Response: Define Medicare compliance. What does Medicare require the provider to submit to confirm compliance and what is the Medicare compliance criteria?

NDMA does recognize a need to review compliancy at 3 months as many cases in the past have been denied, as the recipient is not compliance (using less than 4 hours per night or 20 days of the month) If they are using less than the required amount we must determine if the equipment is truly beneficial and medically necessary.

2. Wheelchair/Seating System

A ND Medical Assistance recipient has an existing wheelchair and seating system that is four years old. Her condition has now changed and requires a new custom molded seating system. Her current wheelchair is of pediatric size and can only go up to 16" in width. Her new seating system will be 18" width and requires a new wheelchair to accommodate it.

NDMA is holding fast to their "five-year rule" for obtaining a new wheelchair…even though it is well documented on the medical need for her new seating system.

This is a 27 year old female in a pediatric wheelchair and cannot have been expected to see her needs change to where an adult size wheelchair is now needed.

Does this not fall under the definition of being looked at on a "case-by-case" basis?

Response: Will not address as this is an individual case. Need to proceed with the appeal process.

3. Wheelchair/Seating System

A ND Medical Assistance recipient resides at the Anne Carlsen Center for Children. He has been ambulatory in the past and has used a facility owned wheelchair during times where he physically cannot walk. An evaluation was performed for him to be fit with his own wheelchair as his condition has been getting increasingly worse. It has been documented that he has experienced multiple falls, his worsening gait pattern and physical problems with Lymphedema in his lower extremities and dislocation of his right patella. He was seen by a Pediatric Physiatrist in June of 2008 and she made the recommendations for this equipment.

NDMA is stating that the recipient is ambulatory and therefore does not meet "Coverage Criteria" for a wheelchair. He indeed does walk very short distances but in a very "Unsafe" manner and could be severely injured should he fall.

Does this not fall under the definition of being looked at on a "case-by-case" basis?

Response: Will not address as this is an individual case. Need to proceed with the appeal process.

4. Ultra-lightweight Wheelchair

A NDMA recipient (secondary) was prescribed an ultra-lightweight manual wheelchair with power assist wheels. His diagnosis is Spina Bifida. He is currently attending Bismarck State College, in his first year. He has applied for a work-study job. In order for him to go from dorm to his classes that are in different areas around campus the power assist wheels are needed to traverse the hilly terrain of the BSC campus while conserving his energy needed for work, school and performs all of his ADL's in a timely manner. He would not otherwise be able to do so without power assist or a power wheelchair.

This wheelchair has been approved by BC/BS (primary). NDMA states that the recipient is ambulatory. But again, the recipiant only walks very short distances and uses them to perform transfers. It has been documented that he has no active movements of his feet and ankles.

A PT from Anne Carlen School called NDMA to further explain why the recipient needed power assist due to his disease. The prior was still denied. According to the PT, the response back from NDMA was "the recipient should find a college with flatter land surface." I do not believe that NDMA can or should dictate to their recipients were they should be going to school.

Does this not fall under the definition of being looked at on a "case-by-case" basis?

Response: Will not address as this is an individual case. Need to proceed with the appeal process.

5. Oxygen

When NDMA developed its O2 policy…it was originally based on Medicare guidelines for coverage.

There are a number of situations where O2 is ordered for children & infants and O2 sat tests are not done. It is very possible that a child's need for O2 may differ significantly than that for an adult, because O2 may be needed for cardiac or failure to thrive situations.

Medicare very rarely covers any children or infants under their benefit. Could there be guidelines of coverage established for children/infants?

Response: Clarify why an O2 sat would not have been obtained before ordering oxygen? Can you supply NDMA with standards of practice for the conditions to which you are referring?

Claims Policy Response: We will not develop new criteria but rather look at oxygen requests for infants on a case by case bases.

6. Oxygen

On January 1st, 2009 many of the Medicare O2 patient's will have their equipment capped-out. Providers will retain ownership of the rental equipment but we will no longer receive any Medicare reimbursement for it.

All ND MAMES Providers are still waiting for a determination from Medicare on what supplies we will be reimbursed for, what we will be reimbursed for O2 contents, and on service to the patient's equipment.

Will NDMA be following the (yet to be developed/released) Medicare guidelines? Will NDMA be developing their own O2 guidelines?

Response: Reference the fee schedule as we have developed quantity limits for oxygen supplies when the equipment is patient owned. We do allow maintenance/repair of patient owned oxygen equipment starting 6 months after which the equipment is patient owned. Maintenance is allowed twice a year and requires prior authorization. Maximum reimbursement allowed is $40 per maintenance visit

7. Hospital Beds

Currently there is no coverage for a full electric hospital bed by ND Medical Assistance or any other insurance carrier. The difference is most all other insurance carriers will allow

a supplier to provide a full electric bed but will only reimburse for a semi-electric, or manual bed. They base their reimbursement on the bed for which the patient qualifies, or on the allowed amount for a semi-electric or manual bed.

In our facility it is not feasible to stock all the different types of beds that are available. The size of our warehouse is limited and our manufacturer gives us a better profit margin when only one type of bed is ordered.

Would it be possible for you to allow ND Providers to provide full electric beds to your recipients, but reimburse us for the bed they meet your coverage guidelines for?

Response: NDMA has submitted policy questions to CMS regarding down coding and are currently awaiting a response from CMS in regards to down coding. Currently we are not allowed to down code. Providers are required to submit the PA request with the specific assigned HCPC code for the item to be dispensed.

Claims Policy Response: NDMA does not recognize full electric hospital beds or low profile GJ tubes as medically necessary. Full electric hospital beds will be reimbursed at the semi electric be allowable and low profile GJ tubes will be reimbursed at the standard GJ tube allowable. See the website for the DME Fee Schedule for allowable.

8. Hospital Beds

A ND MAMES Provider received a denial on a semi-electric hospital bed. The patient can't ambulate because of multiple broken bones including femur and pelvis. NDMA states they will only cover the Hi/Lo bed (which is a manual hospital bed). Why would only a manual bed be approved? How can a non-ambulatory patient be expected to get out of his bed and adjust the head/leg sections. Shouldn't adjustments be necessary if a person were bed confined for 3 to 4 months (which in this case was the length of need)?

Response: Will not address as this is an individual case. Need to proceed with the appeal process.

9. Foot Orthotics and UCB's

Foot Orthotics and UCB's are currently not covered for recipients with diagnoses of CP or diplegia. Could these please be considered?

Response: NDMA will take this issue to claims policy for consideration.

Claims Policy Response: Coverage criteria will not change at this time.

10. Physician Assistant's & Nurse Practioner's

Has there been any reconsideration to allow coverage for items ordered by a Nurse Practioner or Physician's Assistant? There are many rural health clinics within the State of ND that are only staffed with by a NP or PA.

Response: This issue has been addressed with the Medicaid Medical Advisory Committee and will likely be addressed during the next legislative session.

11. ND MAMES Formal Request for Increased Reimbursement

Has there been any determination on the MAMES formal request for additional funding on powered mobility and seating?

Response: This request was submitted as part of the Department's base budget request for 2009-2011.

12. Intermittent Catheters

Will NDMA consider changing allowed amounts for intermittent catheters (A4351, A4352) to match Medicare's current allowed amounts? Medicare changed their allowed amounts in April 2008 to allow up to 120/month of either of these codes if documentation is present in medical record re: # of times/day pt is required to complete intermittent catheterization.

Response: NDMA will take this issue to claims policy for consideration.

Claims Policy Response: Presented but will need to do further research before consideration can be granted.

13. CPAP Supplies

Will NDMA consider matching Medicare's allowed usage on CPAP masks (A7030 & A7034) of one mask every three months? This will decrease the NDMA recipient's out-of-pocket as they are responsible for co-insurance if they receive masks as frequently as Medicare allows (Current NDMA allowance for these codes is one mask every six months).

Response: A7030 and A7034 will continue to allow 2 per year. There is no medical necessity to replace more often than that.

14. CPAP Supplies

Is it necessary to prior authorize CPAP supplies on the initial Prior Authorization? Do MAMES Providers have to resubmit a prior authorization of supplies change, I.E. if the recipient changed from a nasal to full mask?

Response: Supplies do not require prior. NDMA allows 2 masks per year, no matter the type dispensed. Please remember that all supplies, other than the mask and headgear, are included in the rental period.

15. Hypopneas

Medicare has defied criteria as to the number of apneas-hypopneas for equipment coverage. Where do hypopneas fall into on the Medicaid CMN?

Response: NDMA follows Medicare criteria for CPAP:

1. AHI or RDI greater than or equal to 15events per hour of sleep or continuous monitoring, or

2. AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour of sleep or continuous monitoring with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke with other documented symptoms.

3. The only difference is the compliance criterion that is required to be meet for continued coverage.

16. Oxygen Conservers

Will NDMA ever consider covering oxygen conservers?

Response: NDMA follows Medicare criteria for coverage of oxygen equipment. Conservers are non-covered by Medicare and therefore are non-covered by Medicaid.

17. Two-page Priors

When continued two-page priors are given to us from NDMA, the 7th line item is missing. This results in a telephone call to Mary to ensure we did get an approval for that line item and we also request that she sends us a new prior showing the line item is indeed approved.

Is it possible for your system to make a modification to only allow 6 line items per prior authorization number? This would also make the claim sending smoother for the Providers since there are 6 lines per HCFA 1500 claim form.

Response: We do recognize this as an inconvenience to the providers; however, staff is currently detailed to the MMIS replacement project as a priority. We will address this concern in the new system design. Until this can be addressed in the new system, providers can continue to call Medical Services to verify that the item is on the prior and if the item has been approved or denied.

18. Disposable Diapers

Just lately (in the last few months) Providers have been getting prior denials for A4520 code for Diapers deny with the 788.30 (urinary incontinence) diagnoses. The following reason: 1) must have an underlying medical condition in addition to incontinence to meet coverage criteria. Providers have also gotten other diagnosis deny the 596.8 (bladder disorder) and 344.61 (neurogenic bladder) were denied for the following reasons: 1) dx does not meet coverage criteria 2) no diagnosis of incontinence provided with prior auth request.

All of these patients who these priors mentioned above belong to, have had priors approved in the past with these diagnosis (788.30, 596.8 and 344.61) listed alone. The NDMA manual does not state anything about another underlying medical condition unless they are under the age of 4. The NDMA provider manual states the following:

DISPOSABLE DIAPERS (ADULT & YOUTH):
Prior authorization required.

Coverage allowed is the following condition is present:

- Over the age of 4 with an underlying medical condition that involves loss of bowel or bladder control.

- Physicians order is required and must include the duration of need and the medical reason.
- Diapers limited to 180/month.
- Liners limited to 70/month. Prior authorization is required when the liners/ pads and under pads accumulative cost will exceed $500 per year.
- ICF/MR and skilled nursing facility residence are excluded, as the products are included in the facility per diem.
- Only a one-month supply may be dispensed at any time.

Are there updated coverage-criteria that ND MAMES Providers should be following?

Response: There has not been any change to the coverage criteria for incontinence products. There has been some concern with requests meeting coverage criteria. Some requests have been sent back to providers requesting clarification if an underlying medical condition exists. The UR team reserves the right to request additional information or deny a prior at anytime during the review process, if the request does not meet the requirement for coverage.

19. Manual Wheelchair

A Provider has been waiting for approval on a manual wheelchair for a NDMA recipient. The Provider received a DME Memo from NDMA asking, "Is she ambulatory in the home?"

The written confirmation of verbal order signed by the physician states that the patient has mobility limitations that significantly impairs her ability to participate in one or more mobility related activities of daily living in the home. It also states the patient's mobility limitations cannot be resolved by use of a cane, crutch or walker. The order goes on to say the wheelchair will improve the patients mobility related activities of daily living and will be used on a regular basis in the home. The order also states the patient will usually spend 6-8 hours in the wheelchair.

With all the documentation that was provided why would NDMA pose the question, "is she ambulatory in the home"? What else could possibly be given for documentation by the Provider that seems to be missing to NDMA?

Response: The UR team reserves the right to request additional information or deny a prior at anytime during the review process, if the request does not meet the requirement for coverage.

20. Manual Wheelchair

A Provider has another similar question on a wheelchair from NDMA asking "is patient ambulatory in the home"? NDMA also asked the question "is the chair for use primarily outdoors"?

The Provider supplied written confirmation of verbal order, signed by the physician that stated the same points as indicated in question #20. The only difference was the patient will usually spend 4-6 hours in the chair.

Once again, with all the documentation that was provided why would NDMA's question be posed? If the physician states the chair is to be used for daily living in the home why

would the Provider be requested to gather additional information that would totally contradict what a physician is requesting.

Response: The UR team reserves the right to request additional information or deny any prior at anytime during the review process, if the request does not meet the requirement for coverage.

21. Enteral Products

A Provider received a request from a physician to provide an enteral product for a patient whose sole source of nutrition is enteral products. The product prescribed costs more than the NDMA allowable.

The Provider presented an actual invoice to NDMA asking for consideration on additional payment for this product. The request was denied by NDMA stating the "allowable has been set and no exceptions can be offered." The only recommendation to us by NDMA was "see if another Provider would take the patient".

The Provider will/can no longer make available the product/service because the costs exceed the allowable. The Provider cannot find another Provider that is willing to take this patient…because of the same reason.

What would NDMA advise the Provider recommend to the physician and child's parents on where/how to obtain the needed medical nutritional product?

Response: Did the provider inform the physician of the situation and ask if a lower cost alternative could be used? Has the recipient contacted the WIC program? NDMA is not allowed to change the reimbursement rate on a case by case bases.